Modafinil (Provigil) Prior Authorization Request Form

5588

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at: https://rxnet.army.mil/pec/formscriteria.php.

Step 1 Please complete patient and physician information (Please Print)

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 Please complete the clinical assessment

1.	Does the patient have a diagnosis of narcolepsy associated with persistent and excessive daytime sleepiness as diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing?	☐ Yes Please sign and date	☐ No Proceed to Question 2
2.	Does the patient meet BOTH of the following criteria? • A diagnosis of obstructive sleep apnea associated with persistent and excessive daytime sleepiness • Continuous positive airway pressure (CPAP) treatment has been adequately titrated and the patient is compliant with treatment	☐ Yes Please sign and date	☐ No Proceed to Question 3
3.	Is the patient a nightshift worker with a diagnosis of shift-worker sleep disorder (SWSD) associated with excessive sleepiness?	☐ Yes Please sign and date	☐ No Proceed to Question 4
4.	Does the patient meet BOTH of the following criteria? • A diagnosis of multiple sclerosis associated with excessive fatigue • Secondary causes of fatigue have been addressed.	☐ Yes Please sign and date	☐ No Proceed to Question 5
5.	Does the patient have a diagnosis of myotonic dystrophy associated with excessive fatigue?	☐ Yes Please sign and date	☐ No Proceed to Question 6
6.	Does the patient meet ALL of the following criteria? • A diagnosis of depression • Primary antidepressant therapy (defined as a 4-6 week trial of at least one antidepressant agent) has failed. • The use of other stimulant augmentation (such as methylphenidate products) is contraindicated due to adverse effects, previous failure, or hypersensitivity.	☐ Yes Please sign and date	☐ No Proceed to Question 7
7.	Does the patient have a documented diagnosis of idiopathic hypersomnia diagnosed by a sleep specialist?	☐ Yes Please sign and date	☐ No Proceed to Question 8
8.	Does the patient have a diagnosis of fatigue associated with mild traumatic brain injury?	☐ Yes Please sign and date	☐ No Coverage not approved

Step 3 I certify the above is true to the best of my knowledge.

Please sign and date:

_____ _____
Prescriber Signature Date

Latest revision: December 2009